Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: USMD HOSPITAL AT ARLINGTON 801 WEST I-20 ARLINGTON TEXAS 76017	MFDR Tracking #: M4-09-4923-01
Respondent Name and Box #: TRAVELERS INDEMNITY CO. OF CT REP BOX #: 05	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We requested reconsideration…because we feel the carrier denied the claim in error. The original claim was denied for the Medicaid number per the SCR at Travelers but the explanation of benefits state payment was included in the allowance for another service/procedure. Included in the global reimbursement. We submitted reconsideration and the reconsideration was denied for the same reason again. We submitted the claim with the correct information and the claim is still being denied…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $785.50

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "……The Provider has not filed a request for reconsideration in accordance with Rule 133.250…Although the Provider submitted two Explanations of Benefits with the Request, review of those documents demonstrates no request for reconsideration was filed for this date of service. One EOB is for the date of service at issue in this Request for Medical Dispute Resolution, but the second EOB is for date of service 07-01-2008. This second denied bill has also been submitted to Medical Review, under MDR Tracking No. M4-09-4924-01, without being submitted for reconsideration. The Carrier contends the Provider is not entitled to additional reimbursement"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
07/21/2008	Hospital Outpatient Services	$232.77 (APC) + $0.00 (Fee Schedule) + $0.00 (Outlier Amount) = $232.77 (OPPS) x 200% = $465.54 - $0.00 (Total paid by Respondent) = $465.54.	$785.50	$465.54
			Total Due:	$465.54

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 11/12/2008
   - 97 — Payment is included in the allowance for another service/procedure. Included in global reimbursement.
   - 217 — Payment adjusted because requested information was not provided or was insufficient/incomplete.

   Explanation of benefits with the listed date of 12/23/2008
   - 97 — Payment is included in the allowance for another service/procedure. Included in global reimbursement.
   - 217 — Payment adjusted because requested information was not provided or was insufficient/incomplete.
2. Convincing evidence of the carrier's receipt of a request for reconsideration was made in accordance with Rule 133.307(c)(2)(B) as the Requestor submitted initial explanation of benefits dated 11/12/2008 and reconsideration explanation of benefits dated 12/23/08.
3. Pursuant to Rule 134.403(d), CPT Code J1100, CPT Code J1170, CPT Code 1885 and CPT code J2550 are included in the APC rate, but not paid separately. (These are packaged items.)
4. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;…"
5. Pursuant to Rule 134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
6. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
   (1) No contract exists;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.

7. Consequently, reimbursement will be calculated in accordance with Rule §134.403 (f)(1)(A) as follows:

APC Value	Fee Sch	Outlier Payment	Separate Reimbursement for implantables WAS NOT requested under Rule §134.403	APC + Fee Schedule + Outlier Payment X 200%	Subtract Amount Paid by Respondent	Results in additional Amount Due to Requestor
$232.77	$0.00	$0.00	$0.00	$465.54	$0.00	$465.54

8. Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor, USMD Hospital at Arlington, is due additional payment. As a result, the amount ordered is $465.54.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403, TAC Rule §133.307
28 TAC Rule §133.305

PART VII: DIVISION DECISION

The Division hereby ORDERS the respondent to remit to the requestor the amount of $465.54 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature	Medical Fee Dispute Resolution Officer	November 24, 2009 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.